## SECTION 3: PROGRAM DESIGN

## INSTRUCTIONS and FORMS

ITEMS:

25. Program Organizational Chart
26. Program Description
27. Staffing Pattern/Staffing Requirements
28. Accessibility
29. Admissions, Service/Treatment, and Discharge Procedures
30. Evaluation Plan
31. Client Characteristic Chart
32. Program Volume Data (Forms 1 and 1A)
33. Anticipated Program Expenses (Forms 3 and 3S)
34. Anticipated Program Revenue (Forms 4 and 4S)

## SECTION 3: PROGRAM DESIGN

**COMPLETE SECTION 3 FOR EACH PROGRAM**

**25.** **Program Organizational Chart for *Disability Services* and *Delinquency and Court Services:***

Provide an organizational chart which shows in detail, position titles and reporting relationships within the specific program being proposed. Include all positions for which funding is being requested.

**26.** **Program Description for *Disability Services:***

Identify the name and number of the program for which you are requesting funding as it is identified in the *Year 2006 Purchase of Service Guidelines: Program Requirements*. The program description must include the following:

a. Describe the needs to be met, the problems to be solved, and the target population(s) to be served by the proposed program.

b. Describe what services will be provided to meet the identified need and how those services will be delivered.

c. Describe the agency's capability to provide this program, including certification, licensure, and experience, and note any special staff qualifications (credentials, education, experience.)

d. For programs which are provided at more than one site, provide the following information for each site:

(1) Address and telephone number of each site.

(2) Name and title of the person in charge of the program at the site.

(3) Hours of operation of each site.

(4) Differences in programs or services available at each site. If services provided at all sites are identical, include a statement to that effect.

e. Describe service coordination efforts with other programs or agencies including purpose and frequency.

**Program Description for *Economic Support*:**

Organization Name: _____

Service: _____

**History**

Provide a brief history and describe the mission and goals of your organization. Specifically include the number of years **your organization** has been providing the proposed service. (Staff experience will be dealt with in a separate category.) In addition, list your organization's experience in providing services to economically disadvantaged populations. If your organization has not previously provided services to the DHHS, please provide outcome reports or references from other funding sources. Include the name of the parent company and/or affiliated enterprises if the agency is a subsidiary and/or affiliate of another business entity.

**Target Populations**

Identify the following: (a) the target population(s) to be served, (b) the needs to be met and (3) the problems to be solved by the proposed service.

**Program Activities/Work Plan**

Describe in detail how each proposed service will be delivered, and how the program goals and desired outcomes will be achieved. Identify the program activities, sequence of activities, and the usual length of time in each phase, if applicable. Include an action plan and appropriate time frame for program implementation.

Highlight any unique aspects of the program, and describe any service coordination efforts with other programs. If appropriate, provide a Letter of Agreement on the letterhead of the agency signing the agreement. (See the "Sample Letter of Agreement" on page 91)

Describe the program accessibility for non-English speaking persons. Describe any alternate (non-English) language capability in your organization or indicate how interpreter services would be obtained if needed. Describe any other services available to program participants through your organization which are funded through other (non-DHHS) sources.

**Location**

Identify all sites at which services will be offered. For each site, include the address, telephone number, name and title of the person in charge of the program and the site's hours of operation.

**Program Description for *Delinquency and Court Services:***

**a.** **Needs/Problems:** Describe the needs to be met and the problems to be addressed by the program. Please include documentation and data reflecting the scope of the problem or problems in Milwaukee County.

**b.** **Target Population:** Describe the target group to be served by the program.

**c.** **Goals and Objectives:** All program proposals must include measurable program outcomes. For many program areas, the *Program Requirements* book lists mandated program goals and objectives. Define the goals and objectives (both mandated and your own) for your program. Objectives may include process or outcome objectives and for the purpose of program evaluation, **must be measurable**.

**Examples:**

Outcome Objective: Ninety percent of parents who attend a parent skill building program will demonstrate improved ability to meet their child's needs.

Process Objective: Develop a parent skill building group which addresses the parental behaviors which contribute to the abuse or neglect of children.

**d.** **Program Design:** Describe the service delivery system. Include: the type of model to be used (i.e., home visiting model, group work model); a brief overview of the staffing pattern; the time frame for program participation (i.e., 6 weeks, 2 months, full year); and any agency collaborative efforts.

If applicable, describe the sequence of activities, the phases of service/treatment, the length of time in each phase, and the criteria used to determine movement from one phase to another.

**e.** **Specific Program Activities:** List and describe the specific activities to be provided to program participants.

(1) Describe the program activities, purpose of the activity and the usual size, structure, frequency and duration of activities or groups.

(2) Describe how and when individualized client treatment goals and objectives are developed, monitored and reviewed (if applicable).

**PROGRAM SPECIFIC:** *Program Requirements* request that applicants submitting proposals address particular items which are specific to certain programs. Be sure to check the *Year 2006 Purchase of Service Guidelines: Program Requirements* and address these items.

**f.** **Agency Experience**: Describe the agency's experience serving the targeted population; include any existing agency programs that utilize a similar service delivery system. If you are applying as an incumbent, summarize the process and results of the previous year's evaluation. Include any changes made in the program as a result of the evaluation.

**g. Network and Agency Collaboration:** Describe formal and informal agreements with other community agencies or programs which provide services to the target population. Include copies of letters of agreements. (See the "Sample Letter of Agreement" on page 91) Describe the qualifications of agencies and other professionals.

**27. Staffing Pattern for *Disability Services:***

Describe the staffing pattern and its relationship to the volume of clients or services to be provided. For example, describe day service/treatment in terms of staff to client ratios, outpatient services in terms of client volume or case load per staff, and community prevention in terms of how many staff are needed to perform a particular activity. Community based residential facilities must submit a detailed description of how, by staff position, 24-hour coverage will be provided.

Agencies which provide services at more than one site must include a description of the staffing pattern for each site, if different. If the staffing pattern is the same for each site, include a statement to that effect.

***Economic Support:***

Applicants for Economic Support funding must complete the Staffing Requirements Form. (See Staffing Requirements Form, page 92)

***Delinquency and Court Services:***

To complete this item, please provide the following information:

(1) List the complete staff for the program, their responsibilities, hours of work and client-staff ratio.

(2) Describe the qualifications required to fill each position.

(3) Describe the qualifications and experience of current agency staff assigned to the proposed program.

(4) Describe the ongoing staff training program.

(5) Discuss any special coverage needed to provide program services (including holiday, weekend, 24 hour services.) Residential facilities must provide a detailed plan (by staff position), for providing on-site, 24-hour coverage.

(6) Describe the staff's ability to work with speech impaired or non-English speaking people. List the name, position title, and the non-English language spoken. If agency staff is unavailable, explain how interpreter services would be obtained.

(7) Describe the staff's ability to work with or assist families and individuals who have special needs or disabilities.

(8) Discuss the staff's ability to work with the diverse ethnic and cultural populations being served.

**28. <u>Accessibility:</u>**

Provide a detailed description of each of the following items:

a. Accessibility of the program to persons who are physically disabled including building accommodations such as ramps, doorways, elevators, toilet facilities, and if staff is available for persons needing assistance. Include copies of building plans or site surveys. If the program is not accessible, explain where the client would be referred or how disabled clients are accommodated.

b. Accessibility for persons who are hearing impaired. List the name, position title, and level of training (registered or certified, level I or II) of staff who assist in sign language interpreting. Describe the knowledgeable use of TTY or Wisconsin Telephone Relay services. If no staff is available, explain where interpreter services would be obtained. Describe the training opportunities available to existing staff to develop sign language skills and recruitment procedures for hiring trained interpreters.

c. Accessibility of the program for persons who are visually impaired including Braille signage present in the facility, or staff available for assistance in acquainting clients to the facility. Availability of materials in large print, Braille, and/or cassette recordings.

d. Describe program accessibility for limited or non-English speaking persons. List the name, position title, and language (non-English) spoken. If no agency staff is available, explain how interpreter services would be obtained or where the client would be referred.

e. Describe transportation availability to the facility including public, agency provided, or other arrangements.

f. Describe outreach and case finding activities for special target populations such as minorities, women, or adolescents.

g. Describe any differences in accessibility by program site.

h. Availability of personal care assistance.

i. Any other services which enhance program access.

**29. <u>Admission, Service/Treatment, and Discharge Procedures for *Disability Services* and *Delinquency and Court Services:*</u>**

Address all requirements included in the Program Descriptions and Requirements section of these guidelines.

**a. Admissions:**

(1) Describe the criteria used for determining client appropriateness for the program.

(2) Describe the process for screening for appropriateness and admitting applicants to the program. The description of the process should begin with the initial contact and include all activities that occur prior to the establishment of the treatment/service plan. Provide detail about staff positions involved in the intake and assessment process and their roles and responsibilities in the process. Also include a description of the involvement of any specialists such as medical director, psychologist, etc.

(3) Identify the major sources of referral into the program and the approximate percentage of referrals each source generates.

**b. Service/Treatment Process:**

(1) Describe the program activities, purpose of the activity, and the usual size, structure, and schedule of activities or groups.

(2) Describe the sequence of activities, the phases of service/treatment, the length of time in each phase, and the criteria used to determine movement from one phase to another.

(3) Describe how and when individualized client treatment goals and objectives are developed, monitored, and reviewed. Identify by position categories who is involved in this process.

**c. Discharges:**

(1) Describe the basis for discharge decisions and define a successful and unsuccessful discharge.

(2) Describe the discharge process. Include any follow-up activities or monitoring of discharged clients.

(3) Identify community resources to which clients are referred when discharged.

**30. Evaluation Plan:**

a. Identify both program management and client related objectives (i.e., time tables, changes in behavior, numbers served, client satisfaction) which are specific to the program being described. Be sure to include the mandated objectives or outcomes specified in the *Year 2006 Purchase of Service Guidelines: Program Requirements.*

b. Include a time frame and the expected level of achievement for each objective or outcome. Identify by site if appropriate.

c. Describe how the agency will utilize program evaluation results.

The evaluation section of the application should outline who will conduct the evaluation, what data will be collected, what forms or assessment tools will be used. For agencies contracting with an independent evaluator, include the name and experience of the evaluator. For agencies conducting their own evaluation, identify the names of those responsible for the collection and compilation of the data.

**All contract agencies are required to submit semi-annual evaluation reports based on their Evaluation Plan for respective programs. The reports are due 31 days after the end of the first six-month period. For example, evaluation reports for programs contracted in Calendar Year 2005 are due July 31, 2005 and January 31, 2006; evaluation reports for programs contracted in Calendar Year 2006 are due July 31, 2006 and January 31, 2007.**

The semi-annual evaluation of the program should reflect the agency's success in achieving the program's goals.

***Delinquency and Court Services*** evaluations should include the following additional information:

(1) Number of Clients Served
(2) Ethnicity
(3) Age
(4) Zip Code
(5) Diagnosis (when appropriate)
(6) Marital Status of Client

**The evaluation reports should be submitted to the following persons:**

***Disability Services*:** Virgil Cameron, Contract Services Coordinator
DHHS Contract Administration
235 West Galena Street - 3 Mezzanine
Milwaukee, WI 53212

***Economic Support*:** Judy Roemer-Muniz, Contract Services Coordinator
Economic Support Division
Bureau of Employment and Support Services
1220 West Vliet Street, 3rd Floor
Milwaukee, WI 53205

***Delinquency and Court Services:***

Dave Emerson, Contract Services Coordinator
MC Children's Court Center
10201 Watertown Plank Road
Wauwatosa, WI 53226

**31. Client Characteristics Chart:**

Complete and submit the Client Characteristics Chart included in this section on page 94 Specify the number and percent of clients in **each** category within the age, sex, ethnic background, and other sections of the chart. Client Characteristics Chart Definitions can be found on page 93 .

*The total in each category must be equal to the number in Form 1, Column 1, Total Number of Clients to be Served per Year.*

**32. Program Volume Data:**

Complete Forms 1 and 1A, for each program for which funding is requested. The forms and instructions can be found on pages 95-97. *Programs which are funded by site must include separate forms for each site*.

**33. Program Expenses:**

Complete Forms 3 and 3S, Anticipated Program Expenses and Supplementary Sheets for each program and each target population for which funding is being requested. Copies of the forms and instructions for completion are on pages 98-103. *Programs which are funded by site must include separate forms for each site.* Each Form 3 and 3S will appear as a separate column E on Form 5 and column D on Form 5S.

**34. Program Revenues:**

Report projected Year 2006 revenues for each program on Forms 4 and 4S. The forms and instructions are on pages 104-108. *Programs which are funded by site must include separate forms for each site.* Each Form 4 will appear as a separate column E on Form 5A.

**Item #26**

## SAMPLE LETTER OF AGREEMENT

(On Consortium Member's Letterhead)

DATE

Division Administrator
Economic Support Division
1220 W. Vliet Street
Milwaukee, WI 53205

Disabilities Services Division
235 W. Galena Street
Milwaukee, WI 53212

Delinquency and Court Services Division
MC Children's Court Center
10201 Watertown Plank Road
Wauwatosa, WI 53226

Dear:

I am knowledgeable of the consortium of agencies presented by

_____

(Name of lead agency)

to the Milwaukee County Department of Health and Human Services and verify that my organization will be providing services as outlined in the proposal and/or linking with the agency in the manner described.

Sincerely,

_____

Authorized Signature and Title

**YEAR 2006 STAFFING REQUIREMENTS** **Item # 27**
**Economic Support Division (only)**

Indicate the number of staff necessary to achieve your proposal objectives. Provide a job description plus necessary qualifications ("A+B") for each position. Complete "C" for current staff that would actually be working in the proposed program. If no staff person is hired at the time of RFP, indicate vacancy and provide updated staffing form when position is filled.

PROGRAM_____ 2006 PRGM NO._____

POSITION_____ #NEEDED IN THIS POSITION_____

A. Job Description _____

B. Qualifications Needed to Perform Job (include any certifications or licenses necessary to perform job)

C. On Staff Personnel

Employee Name_____

Academic Degree(s)_____

License(s), Certificate(s) _____

Related Work Experience(s)_____

*Vendors requesting funding from the Economic Support Division should be aware that staff providing services must possess qualifications equal to those of Milwaukee County employees who perform similar tasks.*

*Also, an individual must be designated to be responsible for coordination of contractual services. This person will be responsible for maintaining a liaison role with Economic Support and must be accessible during the vendor's normal working hours.*

Agency Name_____

Date Submitted: _____

**Item #31**

## CLIENT CHARACTERISTICS CHART DEFINITIONS

### ETHNICITY DEFINITIONS

1. **Asian or Pacific Islander**: All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes China, Japan, Korea, the Philippine Islands and Samoa.

2. **Black**: All persons having origins in any of the Black racial groups in Africa.

3. **Hispanic:** All persons of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race. (Excludes Portugal, Spain and other European countries.)

4. **American Indian or Alaskan Native**: All persons having origins in any of the original peoples of North America, and those persons who maintain cultural identification through tribal affiliation or community recognition.

5. **White:** All persons who are not Asian or Pacific Islander, Black, Hispanic, or American Indian or Alaskan Native.

### HANDICAPPED DEFINITIONS

A handicapped individual is defined pursuant to Section 504 of the Rehabilitation Act of 1973.

1. Any person who has a physical or mental impairment which substantially limits one or more major life activities (e.g., caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working);

2. Any person who has a record of such impairment; or,

3. Any person who is regarded as having such an impairment.

Item #31

## 2006 CLIENT CHARACTERISTICS CHART

**Agency Name** _____
**Disability/Target Group** _____
**Program Name** _____ **2006 Prgm No.** [ ]
**Facility Name & Address** _____

**CY 2006 Estimated**

**1. Unduplicated Count of Clients to be Served/Year (Form 1, Column 1):**

| | | Number | Percent (%) |
|---|---|---|---|
| **2. Age Group:** | a. 0 - 2 | | |
| | b. 3 - 11 | | |
| | c. 12 - 17 | | |
| | d. 18 - 20 | | |
| | e. 21 - 35 | | |
| | f. 36 - 60 | | |
| | g. 61 & over | | |
| | TOTAL | | |

| | | Number | Percent (%) |
|---|---|---|---|
| **3. Sex:** | a. Female | | |
| | b. Male | | |
| | TOTAL | | |

| | | Number | Percent (%) |
|---|---|---|---|
| **4. Ethnicity*:** | a. Asian or Pacific Islander | | |
| | b. Black | | |
| | c. Hispanic | | |
| | d. American Indian or Alaskan Native | | |
| | e. White | | |
| | TOTAL | | |

| | | Number | Percent (%) |
|---|---|---|---|
| **5. Other:** | a. Handicapped individuals* | | |
| | b. Not applicable | | |
| | TOTAL | | |

***The definitions for "Ethnicity: and Handicapped Individual" can be found in the *2006 Purchase of Service Guidelines - Technical Requirements.***

**Rev 6/05**

**Date Submitted:** _____

## FORM 1 - PROGRAM VOLUME DATA AND UNIT RATE CALCULATION

**AGENCY NAME**

Enter the legal name of the Agency

NAME AND ADDRESS OF PROGRAM SITE

Enter facility name and address. This is required only if the agency provides a service at more than one location. A Form 1 and 1A must be completed for each site (address) if the agency is reimbursed by site.

**AGENCY FEDERAL TAX ID NUMBER**

Specify the agency's tax status Federal Identification Number.

PROGRAM CATEGORY

Enter the **program category or Disability/Target group** exactly as they are identified in the *Year 2006 Purchase of Service Guidelines: Program Requirements.*

PROGRAM NAME

Enter the **program name and number** identifying programs exactly as they are identified in the *Year 2006 Purchase of Service Guidelines: Program Requirements.*

NUMBER OF PROGRAM OPERATING DAYS, HOURS AND CASES/CLIENTS

For direct service or client specific programs, this should represent the actual number of days per week and number of hours per day when services are being provided, and the number of cases (clients) per year that will be seen or provided services.

TYPE OF UNIT

Place an X in the box for an appropriate unit type (day, hour, 1/4 hour or other) on which Units of Service are calculated.

**NOTE:** Only one unit type can be indicated.

Column A: TOTAL PROGRAM UNITS

Specify the number of service units to be provided to each funding source listed in rows 1 to 5. Row 6 equals the total units entered in rows 1 to 5.

Column B: TOTAL PROGRAM COST

Include the projected total budget for this program category regardless of revenue sources. This total must be the same as the "Total Expenses Including Profit" line on Form 3 of the program.

Column C: PROGRAM COST BY FUNDING SOURCE

Indicate and allocate the total program cost to each of the funding sources listed in rows 1 to 5. Row 6 equals the total cost by funding source entered in rows 1 to 5, and should equal the total cost reported in column B.

**Column D: COST PER UNIT**

Indicate the cost per unit for providing services to each of the funding sources. Column D equals Column C divided by Column A.

**FORM 1 - 2006 PROGRAM VOLUME DATA AND UNIT COST CALCULATION**

**AGENCY NAME** _____

**NAME & ADDRESS OF PROGRAM SITE** _____

_____

**AGENCY FEDERAL TAX ID NUMBER** _____

**PROGRAM CATEGORY** _____

**PROGRAM NAME** _____
**(SELECT FROM TABLE OF CONTENTS)** **2006 Prgm No.** ____

**NUMBER OF DAYS PROGRAM OPERATES PER WEEK** ____

**NUMBER HOURS PROGRAM OPERATES PER DAY** ____

**NUMBER OF CASES TO BE SERVED PER YEAR *** ____

**TYPE OF UNIT:** ___ Month ___ Day ___ Hour ___ 1/4 Hour **Other:** _____ **(Specify)**

**COST CALCULATIONS:**

| | TOTAL PROGRAM UNITS (A) | TOTAL PROGRAM COST (B) | PROGRAM COST BY FUNDING SOURCE (C) | COST PER UNIT (D) |
|---|---|---|---|---|
| 1. DHHS Program | | | $ | $ |
| 2. DHHS - LTS Program(s) | | | $ | $ |
| 3. IPN / FFSN Programs or Services | | | $ | $ |
| 4. MCDA (Aging) Program(s) | | | $ | $ |
| 5. Other Programs | | | $ | $ |
| 6. TOTALS | | $ | $ | $ |

*** THIS SAME FIGURE IS TO BE USED AS THE "TOTAL" ON THE CLIENT CHARACTERISTICS CHART**
**A Form 1 must be completed for each site (address) if the agency is reimbursed by site.**

**Rev. 6/05**

**DATE SUBMITTED:** _____

**FORM 1A - UNIT OF SERVICE CALCULATION WORKSHEET**

**Use Form 1A to explain the methodology used to determine the Unit of Service level to be provided for each program included in the application.**

**AGENCY NAME:**

_____

**NAME and NUMBER OF PROGRAM FROM THE YEAR 2006 *PURCHASE OF SERVICE GUIDELINES - PROGRAM REQUIREMENTS:***

_____

**NAME AND ADDRESS OF EACH SITE PROVIDING THE PROGRAM*:**

_____

_____

_____

_____

**PHONE NUMBER:** _____

1. **Explain how the Total Units of Service Per Year figure, shown in Form 1, Column A, was determined and show the actual calculations/method used to arrive at the figures for revenues received from Milwaukee County DHHS; DHHS Long Term Support; Department on Aging; and any Other sources of revenue.**

2. **Divide the Total Cost By Funding Source, Form 1, Column C, by the Total Units of Service Per Year, Form 1, Column A, to show the Unit Cost, Form 1, Column D.**

**Date Submitted:** _____

***A Form 1 and 1A must be completed for each site (address) if the agency is reimbursed by site.**

## FORMS 3 and 3S INSTRUCTIONS

1 - 4 Name of Agency and **Program Name and Number**: Identifying information. Complete as explained for Form 1.

### FORM 3 - ANTICIPATED PROGRAM EXPENSES

Column A - See detailed chart of accounts in this section of these guidelines for account definitions.

Column B - Fill in the 2005 Gross Budget by Control Account as adopted by the agency's Board of Directors or owners of the agency.

Column C - Enter the total 2006 projected annual cost by Control Account as approved by the agency's Board of Directors or owners of the agency.

FROM FORM 4, BRING FORWARD THE TOTAL NON-DHHS CONTRACT REVENUE TO THE CORRESPONDING LINE ON FORM 3.

### FORM 3 S - ANTICIPATED PROGRAM EXPENSES SUPPLEMENTAL SHEET

A supplemental Form 3S is to be used for each Control Account used on Form 3. A supplemental Form 3S is to be used to substantiate the amounts listed in Columns B and C. List only those Sub-Accounts actually used in the Control Account.

On Form 3S, specify by number of each Sub-Account with the corresponding Account Description in Column A; list the 2005 Gross Budgeted amount for each Sub-Account in Column B and the projected 2006 amount in Column C.

### SPECIAL INSTRUCTIONS FOR CONTROL ACCOUNT NUMBER 8000: PROFESSIONAL FEES

In addition to specifying on Form 3S, individual Sub-Account descriptions and budget amounts for each type of Professional Fee expense, include as an addendum to Form 3S, a copy of the actual memorandum of agreement between the agency and the person/agency providing a consultant-type service under the Professional Fee category. The memorandum of agreement should specify the name of the consultant, a description of the consultant functions, the projected number of consultation hours for the year and the hourly/monthly rate (whichever is appropriate.)

**FORM 3 ANTICIPATED PROGRAM EXPENSES**

**Agency Name** _____
**Disability/Target Gp** _____
**Program Name** _____ **2006 Prgm No.** [ ]
**Facility Name** _____
**Address** _____

| | (A) | (B) | (C) |
|---|---|---|---|
| Control Acct. No. | Expenditure Description | 2005 Gross Budget | 2006 Gross Budget |
| 7000 | Salaries | | |
| 7100 | Employee Health & Retirement Benefits | | |
| 7200 | Payroll Taxes | | |
| 8000 | Professional Fees | | |
| 8100 | Supplies | | |
| 8200 | Telephone | | |
| 8300 | Postage and Shipping | | |
| 8400 | Occupancy | | |
| 8500 | Rental, Maintenance & Depreciation of Equipment | | |
| 8600 | Printing and Publications | | |
| 8700 | Travel | | |
| 8800 | Conferences, Conventions, Meetings | | |
| 8900 | Specific Assistance to Individuals | | |
| 9000 | Membership Dues | | |
| 9100 | Awards and Grants | | |
| 9200 | Allocated Costs (From Indirect Cost Allocation Plan, if appropriate) | | |
| 9300 | Client Transportation | | |
| 9400 | Miscellaneous | | |
| 9500 | Depreciation or Amortization | | |
| 9600 | Allocations to Agencies, Payments to Affiliated Organizations | | |
| | TOTAL EXPENSES | | |
| | PROFIT FACTOR | | |
| | TOTAL EXPENSES INCLUDING PROFIT | | |
| | TOT NON-DHHS CONTRACT REV. BROUGHT FWD | | |
| | TOTAL DHHS REQUEST | | |

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**Date Submitted:** _____

## FORM 3S ANTICIPATED PROGRAM EXPENSES SUPPLEMENTARY SHEET

**Agency Name** _____
**Disability/Target Group** _____
**Program** _____ **2006 Prgm No.** _____
**Facility Name and Address** _____

| | | (A) | (B) | (C) |
|---|---|---|---|---|
| Control Acct. No. | Sub-Account Number | Account Description | 2005 Gross Budget | 2006 Gross Budget |
| 7000 | 7001 | Executive Salaries | | |
| | 7002 | Professional Salaries | | |
| | 7003 | Clerical Staff Salaries | | |
| | 7004 | Technical Salaries | | |
| | 7005 | Maintenance Employee's Wages | | |
| | 7006 | Temporary Clerical Help | | |
| | 7007 | Student Stipends | | |
| | 7008 | Other Staff Salaries (Unclassified) | | |
| | | CONTROL ACCOUNT NO. 7000 SUB TOTAL* | | |
| 7100 | 7101 | Accident Insurance Premiums | | |
| | 7102 | Life Insurance Premiums | | |
| | 7103 | Medical & Hospital Plan Premiums | | |
| | 7104 | Pension or Retirement Plan Premiums | | |
| | 7105 | Supp. Payments to Pensioned Employes | | |
| | 7106 | Payments to Annuitants | | |
| | 7107 | Employment Termination Expenses | | |
| | 7108 | Employee Tuition Reimburse. Plan | | |
| | | CONTROL ACCOUNT NO. 7100 SUB TOTAL* | | |
| 7200 | 7201 | FICA Payments (Employer's Share) | | |
| | 7202 | Unemployment Insurance | | |
| | 7203 | Workmen's Compensation Insurance | | |
| | 7204 | Disability Insurance Premiums | | |
| | | CONTROL ACCOUNT NO. 7200 SUB TOTAL* | | |
| 8000** | 8001 | Medical & Dental Fees | | |
| | 8002 | Psychological Fees | | |
| | 8003 | Legal Fees | | |
| | 8004 | Rehabilitation & Education Fees | | |
| | 8005 | Development & Public Relations Fees | | |
| | 8006 | Brokerage, Commission, Collection Fee | | |
| | 8007 | Employment Fees | | |
| | 8008 | Audit Fees | | |
| | 8009 | Electronic Data Processing Service Fee | | |
| | 8010 | Other Contract Payments to Consultants | | |
| | 8011 | Talent Fees | | |
| | 8012 | Other Purchased Services | | |
| | | CONTROL ACCOUNT NO. 8000 SUB TOTAL* | | |

*Must be the same dollar amount as shown on Form 3
**Attach a copy of the memorandum of agreement between the agency and the professional when using Control Account No. 8000, Sub-Account Nos. 8001 through 8012.

## FORM 3S ANTICIPATED PROGRAM EXPENSES SUPPLEMENTARY SHEET

| Agency Name | | | 2006 Prgm No. | |
|---|---|---|---|---|
| | | (A) | (B) | (C) |
| Control Acct. No. | Sub-Account Number | Account Description | 2005 Gross Budget | 2006 Gross Budget |
| 8100 | 8101 | Medicine & Drugs (Clinic Use Only) | | |
| | 8102 | Prosthetic Appliances (Clinic Use Only) | | |
| | 8103 | Recreational, Voc. & Craft Supplies | | |
| | 8104 | Food & Beverages | | |
| | 8105 | Laundry, Linen, & Housekeeping Supplies. | | |
| | 8106 | Office Supplies-Stationery, Typing | | |
| | 8107 | Paper, Ink, Printing, Duplicating | | |
| | 8108 | New Goods Purchased | | |
| | 8109 | Raw Materials (Manufacturing) Purchased. | | |
| | 8110 | Manufacturing Supplies | | |
| | | CONTROL ACCOUNT NO. 8100 SUB TOTAL* | | |
| 8200 | 8201 | Telephone Expense | | |
| | 8202 | Telegraph Expense | | |
| | | CONTROL ACCOUNT NO. 8200 SUB TOTAL* | | |
| 8300 | 8301 | Postage and Parcel Post | | |
| | 8302 | Freight | | |
| | 8303 | Messenger & Delivery Service | | |
| | | CONTROL ACCOUNT NO. 8300 SUB TOTAL * | | |
| 8400 | 8401 | Office Rent | | |
| | 8402 | Other Bldg. & Parking Lot Rent | | |
| | 8403 | Bldg. & Bldg. Eq. Ins. (Gen. & Liability) | | |
| | 8404 | Mortgage Interest | | |
| | 8405 | Electricity | | |
| | 8406 | Gas | | |
| | 8407 | Heating Oil | | |
| | 8408 | Water & Sewer | | |
| | 8409 | Janitorial/Maintenance/Repairs Purchased | | |
| | 8410 | Real Estate Taxes | | |
| | 8411 | Personal Property Taxes | | |
| | 8412 | Licenses & Permits-Occupancy Related | | |
| | 8413 | Bldg. & Grounds Maintenance Supplies | | |
| | 8414 | Miscellaneous Occupancy Costs | | |
| | 8415 | Amortization/Leasehold Improvements | | |
| | 8416 | Depreciation - Buildings | | |
| | | CONTROL ACCOUNT NO. 8400 SUB TOTAL* | | |
| 8500 | 8501 | Equipment rental expenses | | |
| | 8502 | Equipment Maintenance expenses | | |
| | 8503 | Equipment - Depreciation | | |
| | 8504 | Equipment - Interest Expense | | |
| | | CONTROL ACCOUNT NO. 8500 SUB TOTAL * | | |

**Item #33**

## FORM 3S ANTICIPATED PROGRAM EXPENSES SUPPLEMENTARY SHEET

| Agency Name | | | 2006 Prgm No. | |
|---|---|---|---|---|
| | | (A) | (B) | (C) |
| Control Acct. No. | Sub-Account Number | Account Description | 2005 Gross Budget | 2006 Gross Budget |
| 8600 | 8601 | Printing | | |
| | 8602 | Artwork | | |
| | 8603 | Photography | | |
| | 8604 | Recording | | |
| | 8605 | Films | | |
| | 8606 | Subscriptions-Periodicals/Publication | | |
| | 8607 | Purchase of Publications | | |
| | 8608 | Media Use Charges-Public Information | | |
| | | CONTROL ACCOUNT NO. 8600 SUB TOTAL* | | |
| 8700 | 8701 | Local Bus & Taxicab Fares | | |
| | 8702 | Gas & Oil - Company Vehicles | | |
| | 8703 | Repairs - Company Vehicles | | |
| | 8704 | Insurance - Company Vehicles | | |
| | 8705 | Licenses & Permits-Company Vehicles | | |
| | 8706 | Leasing Costs - Company Vehicles | | |
| | 8707 | Auto Allowance(Employees/Volunteers) | | |
| | 8708 | Tires - Company Vehicles | | |
| | 8709 | Hotel, Meals, & Incidental Expenses | | |
| | 8710 | Depreciation - Automotive Equipment | | |
| | | CONTROL ACCOUNT NO. 8700 SUB TOTAL* | | |
| 8800 | 8801 | Meeting Space & Equipment Rental | | |
| | 8802 | Meeting Supplies (Notices,Badges,etc.) | | |
| | 8803 | Food & Beverages Costs(Mtg. Particip.) | | |
| | 8804 | Speaker's Honoraria & Expenses | | |
| | 8805 | Registration Fees | | |
| | | CONTROL ACCOUNT NO. 8800 SUB TOTAL* | | |
| 8900 | 8901 | Medical Fees | | |
| | 8902 | Dental Fees | | |
| | 8903 | Medicines | | |
| | 8904 | Children's Board | | |
| | 8905 | Homemaker Service | | |
| | 8906 | Food Service | | |
| | 8907 | Shelter Service | | |
| | 8908 | Clothing Service | | |
| | 8910 | Recreation Service | | |
| | 8911 | Wage Supplements | | |
| | 8912 | Prosthetic Appliances | | |
| | 8913 | Hospital Fees | | |
| | 8914 | Testing Fees | | |
| | 8915 | Materials - Crafts, Vocation, etc. | | |
| | | CONTROL ACCOUNT NO. 8900 SUB TOTAL* | | |

**Item #33**

## FORM 3S ANTICIPATED PROGRAM EXPENSES SUPPLEMENTARY SHEET

Agency Name | 2006 Prgm No.

| Control Acct. No. | Sub-Account Number | (A) Account Description | (B) 2005 Gross Budget | (C) 2006 Gross Budget |
|---|---|---|---|---|
| 9000 | 9001 | Individual Dues | | |
| | 9002 | Organizational Dues | | |
| | | CONTROL ACCOUNT NO 9000 SUB TOTAL* | | |
| 9100 | 9101 | Grants to Research Institutions | | |
| | 9102 | Graduate Fellowships | | |
| | 9103 | Trainee Scholarships | | |
| | 9104 | Other Scholarships/Tuition Payments | | |
| | 9105 | Allowance for Travel Under Grant | | |
| | 9106 | Allowance for Equipment Under Grant | | |
| | 9107 | Lump Sum Camperships | | |
| | 9108 | Contribution/Grants to Hum. Serv. Org | | |
| | 9109-50 | Awards & Grants to Indiv./Other Org. | | |
| | 9151-99 | Awards & Grants to Affiliate Organizat. | | |
| | | CONTROL ACCOUNT NO. 9100 SUB TOTAL * | | |
| 9200 | 9201 | Administrative Costs (Indirect Costs) | | |
| | 9202 | Transportation | | |
| | | CONTROL ACCOUNT NO. 9200 SUB TOTAL* | | |
| 9300 | 9301 | Local Bus & Taxicab Fares | | |
| | 9302 | Gas & Oil - Company Vehicles | | |
| | 9303 | Repairs - Company Vehicles | | |
| | 9304 | Insurance - Company Vehicles | | |
| | 9305 | Licenses & Permits-Company Vehicles | | |
| | 9306 | Leasing Costs - Company Vehicles | | |
| | 9307 | Tires - Company Vehicles | | |
| | 9308 | Depreciation - Auto Equipment | | |
| | | CONTROL ACCOUNT NO. 9300 SUB TOTAL* | | |
| 9400 | 9401 | Employee Malpractice Insurance | | |
| | 9402 | Employee Bonding Insurance | | |
| | 9403 | Other | | |
| | | CONTROL ACCOUNT NO. 9400 SUB TOTAL * | | |
| 9500 | 9501-9504 | Depreciation or Amortization | | |
| See Accounts Related to the Statement of Expenses in the GUIDELINES. | | | | |
| 9600 | 9601-9690 | Allocations to Agencies, | | |
| | 9691 | Payments to Affiliated Organizations | | |
| | | CONTROL ACCOUNT NO. 9600 SUB TOTAL* | | |
| | | GRAND TOTAL*** | | |

***Must be the same dollar amount as shown on Form 3, on the line titled "TOTAL EXPENSES"

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**Item #34**

## FORMS 4 and 4S INSTRUCTIONS

1 - 4 Name of Agency and **Program Name and Number**: Identifying information. Complete as explained for Form 1.

## FORM 4 - ANTICIPATED PROGRAM REVENUE

Column A - See detailed chart of accounts in the back of this section for account definitions.

Column B - Fill in the 2005 Gross Budgeted Revenues by Control Account. Total the Budgeted Revenue on the line provided. Total Revenue should equal Total Expenses including profit on Form 3.

Column C - Fill in the anticipated 2006 Revenues by Control Account as in Column A. The rest of the procedure for Column C is identical to that for Column B.

## FORM 4 S - ANTICIPATED PROGRAM REVENUE SUPPLEMENTAL SHEET

For each Control Account used on Form 4, use a supplemental Form 4S, to substantiate the amounts in Columns B and C. List only those Sub-Accounts actually used in the compilation of the Control Account. On Form 4S, specify by number each Sub-Account with the corresponding Account Description in Column A, list the 2005 Gross Budgeted Revenue for each Sub-Account in Column B, and the projected revenue amount for 2006 in Column C.

**FORM 4** **ANTICIPATED PROGRAM REVENUE**

**Agency Name** _____

**Disability/Target Gp** _____

**Program** _____ **2006 Prgm No.** _____

**Facility Name & Address** _____

| | (A) | (B) | (C) |
|---|---|---|---|
| Control Acct. No. | Revenue | 2005 Rev. Budget | 2006 Rev. Budget |
| 4000 | Contributions and Donations | | |
| 4100 | Contributions to Building Fund | | |
| 4200 | Special Events | | |
| 4300 | Legacies and Bequests | | |
| 4500 | Collected through Local Member Units | | |
| 4600 | Contributed by Associated Organizations | | |
| 4700 | Allocated by Federated Fund Raising Organizations | | |
| 4800 | Allocated by Unassociated and Non-Federated Fund Raising Organizations | | |
| 5100 | Other Government Purchase of Service (DO NOT INCLUDE ANY REQUESTS FROM DHHS) | | |
| 5200 | Grants from Other Governmental Agencies (DO NOT INCLUDE ANY REQUESTS FROM DHHS) | | |
| 5300 | Revenues From HMO and PPO | | |
| 6000 | Membership Dues | | |
| 6100 | Assessments and Dues-Local Member Units | | |
| 6200 | Program Service Fees - Other | | |
| 6300 | Intra-Agency Sales of Supplies and Services | | |
| 6400 | Revenues from Disposal of Assets | | |
| 6500 | Investment Income | | |
| 6600 | Gains (Losses) on Investment Transactions | | |
| 6900 | Miscellaneous Revenue | | |
| | TOTAL NON-DHHS REVENUE | | |
| | DHHS CONTRACT REQUEST | | |
| | TOTAL REVENUE | | |

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## FORM 4S ANTICIPATED PROGRAM REVENUE SUPPLEMENTARY SHEET

**Agency Name** _____
**Disability/Target Group** _____
**Program** _____ **2006 Prgm No.** _____
**Facility Name and Address** _____
_____

| Control Acct. No. | Sub-Account Number | (A) Account Description | (B) 2005 Revenue Budget | (C) 2006 Revenue Budget |
|---|---|---|---|---|
| 4000 | 4001 | In-Kind Materials | | |
| | 4002 | In-Kind Services | | |
| | 4003 | Unrestricted Cash | | |
| | 4004 | Restricted Cash | | |
| | 4005 | Other | | |
| | | CONTROL ACCOUNT NO. 4000 SUB TOTAL* | | |
| 4100 | | Contributions to Building Fund | | |
| | | CONTROL ACCOUNT NO. 4100 SUB TOTAL* | | |
| 4200 | | Special Events | | |
| | | CONTROL ACCOUNT NO. 4200 SUB TOTAL* | | |
| 4300 | 4301 | Endowments | | |
| | 4302 | Trusts | | |
| | 4303 | Other | | |
| | | CONTROL ACCOUNT NO. 4300 SUB TOTAL* | | |
| 4500 | | Collected Through Local Member Units | | |
| | | CONTROL ACCOUNT NO. 4500 SUB TOTAL* | | |
| 4600 | | Contributed by Associated Organizations | | |
| | | CONTROL ACCOUNT NO. 4600 SUB TOTAL* | | |
| 4700 | | Allocated by Federated Fund Raising Org. | | |
| | 4701 | United Way | | |
| | 4702 | Other | | |
| | | CONTROL ACCOUNT NO. 4700 SUB TOTAL * | | |
| 4800 | | Allocated by Unassociated and Non-Federated Fund Raising Org. | | |
| | | CONTROL ACCOUNT NO. 4800 SUB TOTAL* | | |

*Must be the same dollar amount as shown on Form 4.

## FORM 4S ANTICIPATED PROGRAM REVENUE SUPPLEMENTARY SHEET

**Agency Name** _____ **2006 Prgm No.** _____

| | | (A) | (B) | (C) |
|---|---|---|---|---|
| Control Acct. No. | Sub-Account Number | Account Description | 2005 Revenue Budget | 2006 Revenue Budget |
| 5100 | 5101 | Title XX-Milwaukee County (Do not include any DHHS Requests) | | |
| | 5102 | Title XX-Other Counties | | |
| | 5103 | Title IVA (AFDC Unemployment Actual)-Milwaukee County | | |
| | 5104 | Title IVA (AFDC Unemployment Actual)-Other Counties | | |
| | 5105 | Title IVA (WEOP) - Milwaukee County | | |
| | 5106 | Title IVA (WEOP) - Other Counties | | |
| | 5107 | 51.42/.437 - Milwaukee County | | |
| | 5108 | 51.42/.437 - Other Counties | | |
| | 5109 | Title I - Milwaukee County | | |
| | 5110 | Title I - Other Counties | | |
| | 5111 | Title III - Milwaukee County | | |
| | 5112 | Title III - Other Counties | | |
| | 5113 | USDA Food Stamps | | |
| | 5114 | Title XVIII - Medicare | | |
| | 5115 | Title XIX - Medicaid | | |
| | 5116 | Social Security and SSI | | |
| | 5117 | CIP Revenue from Milwaukee County | | |
| | 5118 | CIP Revenue from Other Counties | | |
| | 5119 | COP Revenue from Milwaukee County | | |
| | 5120 | COP Revenue from Other Counties | | |
| | 5121 | Target Cities Voucher Revenue | | |
| | 5122 | Other | | |
| | | CONTROL ACCOUNT NO. 5100 SUB TOTAL * | | |
| 5200 | 5201 | Direct Federal Grants | | |
| | 5202 | Direct State Grants | | |
| | 5203 | Direct County Grants | | |
| | 5204 | Direct City and Municipal Grants | | |
| | 5206 | Title III Grants | | |
| | 5210 | Other Grants from Governmental Agencies | | |
| | | CONTROL ACCOUNT NO. 5200 SUB TOTAL* | | |
| 5300 | 5301 | Revenue from Title XIX-AFDC Clients | | |
| | 5302 | Revenue from Non-Title XIX Clients | | |
| | | CONTROL ACCOUNT NO. 5300 SUB TOTAL* | | |
| 6000 | | Membership Dues - Individuals | | |
| | | CONTROL ACCOUNT NO. 6000 SUB TOTAL* | | |
| 6100 | | Assessments & Dues-Local Member Units | | |
| | | CONTROL ACCOUNT NO. 6100 SUB TOTAL* | | |

*Must be the same dollar amount as shown on Form 4.

## FORM 4S ANTICIPATED PROGRAM REVENUE SUPPLEMENTARY SHEET

| Agency Name | | | 2006 Prgm No. | |
|---|---|---|---|---|
| | | (A) | (B) | (C) |
| Control Acct. No. | Sub-Account Number | Account Description | 2005 Revenue Budget | 2006 Revenue Budget |
| 6200 | 6201 | Income from Private Pay Clients | | |
| | 6202 | Income from Title IVA (AFDC Employed Actual) Clients | | |
| | 6203 | Income from Title XX Clients (Direct Pay Portion Only) | | |
| | 6204 | Income from 51.42/.437 Clients (Direct Pay Portion Only) | | |
| | 6205 | Income from Client Pick-up and Delivery Charges | | |
| | 6206 | Income from Client Insurance Carriers (Other then Medicare - Title XVIII) | | |
| | 6207 | Other Third Party Non-Governmental Income | | |
| | CONTROL ACCOUNT NO. 6200 SUB TOTAL* | | | |
| 6300 | | Intra-Agency Sales of Supplies&Service | | |
| | CONTROL ACCOUNT NO. 6300 SUB TOTAL * | | | |
| 6400 | 6401 | Sale of Production | | |
| | 6402 | Sale of Property & Other Assets | | |
| | 6403 | Sale of Staff Services | | |
| | CONTROL ACCOUNT NO. 6400 SUB TOTAL* | | | |
| 6500 | 6501 | Interest | | |
| | 6502 | Dividends | | |
| | 6503 | Other | | |
| | CONTROL ACCOUNT NO. 6500 SUB TOTAL* | | | |
| 6600 | | Gains (Losses) on Investment Trans. | | |
| | CONTROL ACCOUNT NO. 6600 SUB TOTAL * | | | |
| 6900 | | Miscellaneous Revenue | | |
| | CONTROL ACCOUNT NO. 6900 SUB TOTAL* | | | |
| | GRAND TOTAL** | | | |

*Must be the same dollar amount as shown on Form 4.
**Must be the same dollar amount as shown on Form 4, on the line titled "TOTAL NON-DHHS REVENUE"

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